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World Vision Relief & Development, Inc.

WVRD/Indonesia
FINAL EVALUATION REPORT
Sanggau Child Survival Project
West Kalimantan, Indonesia
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LIST OF ABBREVIATIONS

ADRA	Adventist Development and Relief Agency
ANC	antenatal care
AR1	acute respiratory infection
BCG	Bacille Calmette-Guerin (tuberculosis vaccine)
BHR/PVC	Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (USAID)
CDD	control of diarrhea1 diseases
CHW	community health worker
CQI	Continuous Quality Improvement
CS	Child Survival
CSSP	Child Survival Support Program (of Johns Hopkins University)
DIP	detailed implementation plan
DPT	diphtheria, pertussis and tetanus (vaccine)
EPI	Expanded Programme on Immunization
FY	fiscal year
GOI	Government of Indonesia
HKI	Helen Keller International
HMIS	health management information system
HMO	health maintenance organization
KPC	knowledge, practice, and coverage (survey)
MCH	maternal and child health
MOH	Ministry of Health
MOU	memorandum of understanding
MTE	mid-term evaluation
NGO	non-governmental organization
OPV	oral polio vaccine
ORS	oral rehydration salts
ORT	oral rehydration therapy
PC1	Project Concern International
PHC	primary health care
PHN	public health nurse
PMT	*posyandu* management team
PNC	post-natal care
PRA	participatory rural appraisal
PVO	private voluntary organization
Rp	Indonesian rupiah (unit of currency)
SCSP	Sanggau Child Survival Project
SSS	sugar-salt solution

LIST OF ABBREVIATIONS
(continued)

TBA	traditional birth attendant
UI	University of Indonesia
UNFPA	United Nations Family Planning Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WV	World Vision
WV1	World Vision International
WV/I	World Vision/Indonesia
WVRD	World Vision Relief and Development
YHK	***Yayasan Harapan Khatulistiwa***
YSF	***Yayasan*** Samaria Foundation

DICTIONARY OF INDONESIAN TEEMS AND ABBREVIATIONS

arisan	savings group, usually of 10 to 20 households, often using a weekly lottery to award the funds
bidan desa	village midwife
BKKBN	National Family Planning Coordinating Board
Bupa ***ti***	District Chief
Camat	Sub-district Chief
dana sehat	community-based health insurance scheme
dasa wisma	unit of 10 to 20 households in which the (generally) women work together in community development activities
desa	village, comprised of several hamlets
dukun bayi	traditional birth attendant
dusun	hamlet, (of which there are usually several within a desa
DEPKES	Department (Ministry) of Health
DEPSOS	Department (Ministry) of Social Affairs
ganjur	harvest festival, often several weeks in duration
gotong royong	community self-help group
kader	village health or community development volunteer
karung ***taruna***	village youth group
kon tak tani	village development facilitator
KUEP	cooperative for micro-enterprise or income-generating activities
LKMD	village council
PKK	Family Welfare Organization Movement
PKKBD	community-based contraceptive distribution center
pol indes	village delivery homes
pos obat desa	village drug post
posyandu	integrated village health service post
PPPK	first aid
puskesmas	subdistrict community health center
yayasan	local non-governmental organization

WORLD VISION/INDONESIA
SANGGAU, WEST KALIMANTAN
Final Evaluation

The Sanggau Child Survival Project (SCSP) has been implemented by World Vision (WV) in two subdistricts of the Sanggau District of West Kalimantan Province in Indonesia. This CS8 project began in October 1992, and will be completed on September 30, 1995. The total budget of $781,450 includes a USAID contribution of $533,700.

Working among the predominately Dayak people in the Kapuas river basin, the SCSP serves a population of 31,152 (6483 families) in two subdistricts, including 3884 children under five and 8187 women 15 to 49 years of age. These project beneficiaries are scattered over 654 square kilometers in 19 villages (*desas*), which are further divided into 84 hamlets *(dusuns).* Most families earn their living through "slash and burn" agriculture and by tapping rubber trees in the remaining rain forest. Nearly half (43%) of mothers are non-literate.

Health infrastructure available at the outset of the project included three *puskesmas* (community health centers), six sub-centers *(puskesmas pembantu),* and 42 integrated health service posts *(posyandus).* The *posyandus* provide village-based, community financed preventive health services through monthly sessions for growth monitoring, immunization, antenatal care, family planning, an r separate system for promotion of family planning uses'8 family planning field workers (and one supervisor) who work through 19 village-based contraceptive distribution centers (*PKKBDs*) and 84 sub-*PKKBDs.*

Health personnel in the project area include two physicians, five midwives, four vaccinators, and five public health nurses (PHNs) who are based in the *puskesmas* but provide or support the periodic delivery of health services through the *puskesmas pembantu* and the *posyandus.* Of the 209 health and development promoters *(kaders)* who were in the project area at the beginning of the project, only 95 were active due to lack of supervision. There were 90 *dukun bavis* (traditional birth attendants or TBAs) working in the project area at the time the project began, few of whom had any formal training or equipment. While the TBAs generally receive a small fee from their clients, the *kaders* work as volunteers.

The project is implemented in collaboration with two local NGOs (*yayasans*), *Yayasan Samaria Foundation (YSF)* and *Yayasan Harapan Khatulistiwa (YHK).* The 19 community health workers (CHWs) who

are paid with project funds are staff of these two local **NGOs.** SCSP staff have also collaborated with the Family Welfare Organization **(*PKK*)** and the Ministry of Health **(*DEPKES*)** in the design and implementation of the project.

I. PROJECT ACCOMPLISHMENTS AND LESSONS **LEARNED**

> ***"SCSP has helped to create a health culture in the beneficiary communities, helping people to see the importance of activities to improve their own health"*** **(*DEPKES* official – Pontianak)**

The achievements of SCSP have made the project a clear success. These achievements are all the more impressive in view of the brief duration of the period of actual service delivery. Approximately the first **15** of the **36** months of the project were spent in development of the project's management structure, completion of a census in the project area, and preparation of the beneficiary communities for full participation in health and community development activities.

A. Project **Accomplishments**

Specific achievements by objective are presented in tables in the sections below, including for both overall project objectives (page 6) and the sustainability objectives (pages 24-26). However, the evaluation team noted **several** outstanding achievements which should be specially highlighted:

> ***"Before the dasa wisma was organized in my village, we ate no vegetables and did not understand about vitamin A. Now we have home gardens and understand the importance of eating vegetables."*** **(Community Health Worker, Empirang Ujung)**

- The project has been instrumental in establishing 50 ***dasa wismas*** (units of **10** to **20** households in which women work together in community development activities). These groups are a powerful mechanism to promote community organization and development, especially to empower the women in these communities.
- SCSP has also worked with communities to organize 8 *dana sehats* (community-based health insurance organizations), which now provide health insurance for more than **100**

households in the project area. These *dana sehats* are designed according to the perceived needs of the members, with some also functioning as health maintenance organizations (HMOs) or providing special assistance for the needy.

- SCSP has succeeded in achieving a level of intersectoral collaboration which had not previously been possible in West Kalimantan. The project has created a synergy among health, education, and agricultural sectors at district and provincial levels and has created hopes that other programs may successfully strive to attain a similar integration of community development efforts.

> *"The SCSP has been able to bring together representatives from all sectors - education, agriculture, social services, and health - where it has been difficult for us to achieve such intersectoral collaboration before"* (DEPKES official - Pontianak)

- Communities have perceived a reduction in cases of diarrhea where piped water supply systems have been installed. This perceived reduction is substantiated by a decrease in the annual number of diarrhea cases seen in one *puskesmas* from 69 cases in 1993 to 49 cases in 1994.

- Complementing this effect in diarrhea control, SCSP has also successfully promoted the increased use of ORT, as reflected in ORT use rates which have increased from 27% to 75% over the course of the project.

- The percent of children fully immunized increased significantly in the project area, with full coverage among children 12 to 23 months of age rising from 36% to 66% during the project period. The proportion of mothers receiving two doses of tetanus toxoid tripled from 10% to 30%.

- Although targets are for more frequent use of antenatal and postnatal care, great strides were made in promoting increased use of antenatal care. The proportion of women who made at least one visit for antenatal care increased from 0% (estimated from project records) to 77%, including maternal report.

- Vitamin A coverage was increased significantly during the project period, with the proportion of postpartum mothers

receiving vitamin A increasing from 0% (though not measured at baseline) to 58% and the proportion of children 12 to 23 months receiving semiannual doses increasing from 19% to 75%.

- Observers note significant effects of capacity-building at the village level, reflecting the impact of training for *kaders* and other village leaders in CS interventions and community development skills (including management of community-based health insurance and savings and loan associations).

- As the project has achieved its quantitative targets, it has begun to make an appropriate shift in emphasis to strengthening the quality of its activities, such as through introduction of operational standards through supervisory checklists.

A.1. Project Accomplishments by Objective

Objectives outlined in the DIP were revised in the first annual report and at the time of the MTE. The target for tetanus toxoid coverage (2 doses) among mothers who delivered in the past 12 months was adjusted from 70% to 80%, in response to recommendations received in the review of the project's DIP. The objective for vitamin A supplementation of postpartum women was changed to target mothers within one month (rather than two weeks) of delivery. The objective for ORT competence was adjusted to target **all** households, rather,than only those "registered" by the project.

Two other objectives originally included in the DIP were eliminated at the time of the first annual report, including for referral of high risk pregnancies and for growth monitoring coverage and referral. Data for the first 10 months of the project suggest that growth monitoring coverage had already increased from 30% to 42%. However, the decision was made to eliminate this objective because it was "so labor-intensive, time-consuming, and so dependent on proper counseling skills and follow-up". Project staff, however, continued to promote participation and provide technical support for the growth monitoring activities at the *posyandus.*

The objective for referral of only 60% of women with high risk pregnancies was eliminated, since **all** women found to be at high risk were promptly referred (and SCSP staff recognized that referral of less than 100% of those detected to be at high risk would constitute poor practice).

The following table summarizes the project objectives and outlines the achievements by objective. Data for this table come from the three knowledge, practice and coverage (KPC) surveys conducted by the project at baseline, mid-term, and the end of the project. Because of the sampling method used for the survey, the indicator population, for the diarrhea1 disease control (CDD) objectives which specify children under five, is actually children under two. For those objectives which specify infants or women delivered in the last 12 months, the analysis of the survey data has been limited to that group. Detailed information regarding the sources of data and methods of calculation of these indicators is supplied in attachment A.

Differences between the project objectives and the actual achievements are due to many factors. These include both factors which favored achievement and factors which hindered achievement of objectives (or resulted in falsely low measures of success). Factors which heightened project success include:

- The perception and expression of needs by *puskesmas* staff, prior to the development of the CS project, for assistance with strengthening of CS interventions.
- The reliable provision of support and supplies (vaccines, vitamin A, ORS, heath education and training materials.
- The dynamic and responsive nature of government partners, including at district, provincial, and national levels. Because of this strength of local government, it has been possible for SCSP to create and maintain a strong collaboration between WV/Indonesia and the government.

Some of the factors which interfered with project success (or its documentation) include the following:

- The short duration of the project, especially in view of the need to spend much of the project effort during the first 15 months completing the population registration and ensuring that communities were prepared to participate fully in project activities and decision making.
- The limited transportation infrastructure and resulting difficulty of obtaining access to most of the population of the subdistrict, especially during the rainy season, when many villages accessible only by motorbike can no longer be reached.
- The limited availability of community members, especially mothers, most of whom are away from home during the day for work in the fields or tapping rubber trees.
- The relatively low literacy rate and language barriers, which are constraints to social mobilization and slow the development of strong community participation.
- The cultural constraints to improving nutrition during pregnancy and lactation (due to food taboos) and increasing utilization of antenatal and postnatal care (postpartum women are proscribed from leaving their homes for 40 days after birth).
- The documentation of the impressive successes of SCSP was hampered by the selection of difficult and demanding objectives, with excessively complex indicators, and overambitious targets.

A.2 Unintended Effects of Project Activities

The evaluation team, SCSP staff, and partners noted both positive and negative unintended effects of the project. Some of the positive effects included:

- Project successes have elicited considerable pressure on project staff to expand geographically. This desire on the part of political and ***DEPKES*** leadership to provide SCSP services in a more remote area will help to assure smoother operations in the more difficult areas suggested by the provincial and district officials.

- ***Arisans, dasa wismas,*** and ***dana sehats*** promoted a sense of community solidarity and empowerment which helped to promote increased participation in other health-related activities, such as immunization, growth monitoring, gardening, and water supply activities.

- The ***dasa wismas*** provide such a potentially powerful interface with the target communities that ***puskesmas*** staff want to use these women's groups to provide health information to assist planning and resource allocation.

- Although ***dasa wismas*** were designed as organizations for women, a few ***dasa wismas*** with solely male members have developed, providing evidence that these are perceived as credible and beneficial by the male members ***of*** these communities. These male-run organizations may also be "empowering" for men who are marginalized by recent changes in these traditional societies which leave little role for men who are no longer engaged in warfare.

- The consultant-assisted review of SCSP's HMIS helped to stimulate an interest in quality assurance on the part of ***puskesmas*** staff and an expressed hope that the HMIS might be replicated by the ***DEPKES*** at the provincial level.

- SCSP's efforts to promote development of the ***pos obat desas*** resulted in the development of a simple and innovative inventory tracking system in one of these village drug posts which may be used in other ***pos obat desas*** in the project area.

- Some of the USAID standards for project management and evaluation will be generalized to in other WV projects. Use of a detailed implementation plan (DIP), technical standards for program design, and use of a KPC survey are three examples of USAID-inspired standards which will have an impact on non-USAID-funded WV activities.

A few unintended negative effects were also highlighted during the evaluation. These include:

- The ***dasa wismas,*** which were established to improve health status, have engendered so much excitement regarding their income-generating activities that the health objectives are sometimes obscured.

- Savings organizations, including ***arisans*** and ***dana sehats,*** accumulate funds which can be (and were, at least in one case) used inappropriately as capital to obtain loans, thereby increasing the debt load in beneficiary communities.

- The high credibility associated with TBA ***(dukun bayi)*** training has resulted in some mis-use of equipment in the TBA kits when untrained **TBAs** "borrow" the TBA kits for use in their own deliveries. This phenomenon, along with late receipt (months after completion of training) of the TBA kits, has been associated with development of poor habits in the use of the equipment.

A.3 Final Evaluation Survey

The final evaluation survey was coordinated by Dr. Mary Wangsarahardja and the SCSP core team between August 26 and September 7, 1995. A copy of the final evaluation survey report, including data for the "key indicators", is attached as appendix B.

B. Project Exnenditures

B.l Pineline Analysis

The pipeline analysis of project expenditures presented below shows the expenditures as planned in the DIP budget, actual expenditures to date (10/1/92 to 9/30/95), and balance (or over-expenditure) by line item for both the USAID contribution and WV match.

LINE ITEM	BUDGET		ACTUAL		BALANCE	
	USAID	WV	USAID	WV	USAID	WV
DIRECT COSTS						
Supplies	27,150	8,825	21,720	14,167	5,430	(5,342)
Equipment	21,990	58,850	14,054	55,826	7,936	3,024
Consultants	43,305	0	45,865	0	(2,560)	0
Evaluation	31,170	0	23,161	0	8,009	0
Personnel	161,422	0	194,763	0	(33,341)	0
Travel						
Local	46,266	0	55, 512	0	(9,246)	0
Intemat.	11,505	0	0	0	11,505	0
Other	106,140	0	88,706	0	17,434	0
TOTAL DIRECT COSTS	448,948	67,675	443,781	69,993	5,167	(2,318)
INDIRECT COSTS						
Headquarters (20% of direct, less equipment, GIK, and GIK transport)	84,752	1,765	*85,945*	2,833	(1,193)	(1,068)
Field admin. and program support	0	178,310	0	174,924	0	3,386
TOTAL INDIRECT COST	84,752	180,075	*85,945*	177,757	(1,193)	2,318
GRAND TOTAL	533,700	247,750	*529,726*	247,750	*3,974*	0

B.2 Comparison of Pipeline to DIP Budaet

The actual expenditures as of the end of the project compare closely to the expenditures planned in the DIP. Over-expenditures in the personnel line item were entirely offset by under-expenditures for equipment and evaluation. Larger than anticipated costs for local travel were covered through

underexpenditure of the line item for international travel. Overall, a slight budget surplus of $3,974 remains of the USAID contribution as of the end of the project.

C. Lessons Learned

The evaluation team, in consultation with project staff, partner organizations, and communities, articulated several lessons which were learned in the course of project implementation. The "lessons learned" which are outlined below are selected as those which may be of greatest use to other CS projects, both within Indonesia and globally. They are categorized as being chiefly relevant to overall implementation strategies, to specific interventions, or to sustainability issues.

c.1 Imolementation Stratecries

Lessons learned with regard to overall strategies for project implementation have been grouped below as primarily relevant to HMIS, human resources management, and technical support of the project. They may be summarized as follows:

Health Manaaement Information Svstems:

- The HMIS should be designed and field-tested to assure that the information it collects is simple and precise, and may be presented in reports which are relevant and understandable to the community.

- Annual KPC surveys for monitoring and evaluation of a three year CS project are probably too frequent, especially if that project is new. However, the KPC survey data clearly helped to refine project objectives and to galvanize both project staff and SCSP partners to attain project goals.

> *"We would like to know when the next survey will be performed, so we can see further improvements of these measures."* (Provincial *DEPKES* representative)

- Particularly in a project of only three years duration, extensive investments in development of the HMIS are unlikely to yield adequate benefits prior to project completion. In this project, now that the vital events reporting and death investigations are being performed routinely, more effort will be required to assure that managers, health workers and community members experience the utility of this information.

- Few CS projects use data regarding the prevailing causes of death (along with data regarding the cost of intervention delivery) to assess the potential cost-effectiveness of CS interventions. Particularly in projects with vital events

reporting and death investigations, these data should be used to estimate the expected cost-effectiveness of specific interventions to reduce mortality.

- The project's decision not to proceed with the planned neonatal death survey was appropriate, and freed resources which were more profitably used to achieve SCSP service-delivery objectives.

- Involvement of the community in monitoring and evaluating project activities helps to ensure sustainability through the resulting increased accountability to beneficiaries.

- Considerable unnecessary effort was expended in measuring "competence" in use of ORT. Although the survey instrument provided some of the necessary information only for the (40) mothers of children with diarrhea, all (300) mothers were asked to demonstrate ORT mixing. This wasteful effort might have been avoided through a pre-survey review of methods for calculating each indicator from survey data.

- This project, like many CS projects designed at this time, experienced considerable pressure to select complex objectives (including for ORT competence and appropriate infant feeding) and overly ambitious targets (including those for immunization and antenatal care). This selection of difficult and demanding objectives, with excessively complex indicators, hampered documentation of project successes and led the staff to be disappointed about "failing" to reach targets for those objectives.

Human Resources Manaaement:

- Team-building is instrumental in ensuring project success, and should be a focus of early project activities in human resource management.

- Formally defined relationships (e.g., written job descriptions) and frequent structured interaction (e.g., monthly meetings) are essential in ensuring a functional management structure for CS activities.

- Field staff for rural areas are more successful if recruited from the village in which they will work or the immediate area.

- Although trainings conducted at the village level incur additional operational costs, these may nevertheless be more cost-effective, since many more can benefit from the training and the content can more easily be made relevant to the situation in which the trainee will work.

- Additional technical support from PVO/CSSP and/or BHR/PVC is required regarding methods for identification of training needs for CS projects.

- Selection of candidates for training programs is critical in assuring the success of human resource development activities. After health workers have been working for several months in the jobs for which they are trained, CS projects should be willing and able to reassess the selection criteria for participation in the training.

- Attrition among volunteer health workers, including the ***kader*** in Indonesia, is a nearly universal problem. Creation or strengthening of professional networks, including through regular meetings or refresher training, can be instrumental in maintaining a sense of solidarity and motivation among such workers.

> ***"These activities will certainly be sustainable. Because of the training we have received, we will continue to work together to improve the health in our communities, even after the project is over"*** **(CHW – Senyabang)**

Technical Suonort:

- The project's use of local sources of technical support has helped to assure that the TA has been locally appropriate. Even more importantly, however, use of experts from within Indonesia has helped to build a constituency for the project, at district, provincial, and national levels.

- Considerable effort was expended in response to the recommendations of the mid-term evaluation. Though most of the recommendations were helpful, project staff should be encouraged to "pick and choose" among recommendations made during evaluations, implementing only those recommendations with which they concur, based on their knowledge of the local context.

c.2 Specific Interventions

Key lessons learned for each category of intervention include the following:

Immunization:

- Posting of child-specific health records (such as that designed by PATH, in which a body part is colored for each dose of vaccine or vitamin A until the entire diagram of the child is completed) on the walls of the *posyandu* has apparently been effective in motivating mothers to seek necessary preventive care.

- Failure of the PHN to appear for *posyandu* immunization sessions has frequently resulted in missed opportunities for

immunization and probably contributed to poor ***posyandu*** attendance rates, as well as reduced utilization of other health services.

- Women's **fears** regarding adverse effects of immunization (including fever) remain a barrier to compliance with immunization schedules. More education is required to encourage women to view the adverse effects of immunization as normal and tolerable, relative to the benefits.

Control of Diarrhea1 Disease:

- Collaborative problem-solving with communities has been effective in establishing water-related health problems as a community priority, in identifying causes and possible solutions to reduce water-related diseases, and in implementing and monitoring the effectiveness of interventions to improve the quantity and quality of water supplies.

> ***"Before SCSP, we had a tradition of using river water. Although it took some time, now we understand how dangerous the river water can be. We have a sense of solidarity in the village to improve our health"*** **(Treasurer – Area B)**

- CDD objectives which specify demonstrated 'competence' in the use of ORT are important, but time-consuming, costly and difficult to measure. Efforts should be made to ensure that such indicators are as simple as possible, and designed to require demonstration of mixing by only a limited subset of mothers.

- Sustaining improvements in the level of ORT use requires consistent efforts in "social marketing".

- Strategies for ORT promotion, including principal reliance on sugar-salt solution, require critical review. "Benchmarking" with other agencies (both governmental and non-governmental) may help to identify a more technically and culturally appropriate strategy, such as using home-available fluids.

Nutrition and Vitamin A:

- SCSP, like many other CS projects, has been subjected to a series of technical consultations with alternating positive and negative views of the effectiveness of growth monitoring and nutritional counseling programs in reducing the prevalence of malnutrition.

- Although malnutrition is an important factor in child mortality, CS projects have generally not been successful in

reducing its prevalence solely through growth monitoring and nutritional counseling programs.

- With low rates of attendance at the ***posyandu,*** children at high risk of malnutrition are those least likely to regularly attend growth monitoring. In addition to promoting attendance at growth monitoring sessions, CS projects should consider efforts to detect and treat malnutrition in other settings, such as through cooperative day care programs.

- Project data (from exit interviews for the ***posyandu*** quality checklist) confirm that most nutritional counseling is ineffective. Most mothers **(68%)** cannot interpret the growth card and nearly half (45%) report they received no explanation of the graph during growth monitoring sessions. Noisy and crowded group sessions, especially where others are waiting for services, are not the most appropriate environments for nutritional counseling and education.

- The care of children by older siblings, neighbors, or relatives while the mother is away may place these children at increased risk of malnutrition. Although most CS projects have data regarding the prevalence of such child care practices, few have correlated this with nutritional status to determine the importance of this as a risk factor for malnutrition.

- New and creative solutions are required to address the persistent problem of malnutrition. Increased attention to the role of chronic and recurrent infection (such as with intestinal parasites, diarrhea, or **ARI)** and the social context which supports poor feeding practices (such as occupational and child care practices) may be required to identify strategies to prevent rather than simply identify cases of malnutrition.

- Coverage objectives for vitamin A distribution to postpartum women are difficult to achieve unless capsules are administered by the personnel who attend most deliveries. Achievements may approach the SCSP target for this objective if ***dukun bayis*** (who deliver **78%** of mothers) are empowered to distribute vitamin A to these mothers.

Maternal Care and Family Planning:

- To achieve major changes in the utilization of antenatal and postnatal care will require addressing the sociocultural constraints regarding the behavior of mothers during pregnancy and after delivery.

- The training of **TBAs** and provision of outreach antenatal care have undoubtedly raised community consciousness regarding the problem of maternal health. However, significant reductions in the high rates of maternal

mortality in the project area, as in most developing countries, will ultimately require improved access to surgical care for intrapartum emergencies, including hemorrhage and obstructed labor.

- Changing the practices of **TBAs,** especially the older ones, is difficult. Although younger **TBAs** are more easily trained to adopt safer birth practices, these younger practitioners are not yet as well trusted or utilized in their communities.

Care of the Sick Child:

- There is a strong reluctance, including among physicians trained in AR1 management, to make appropriate antibiotics available at the village level for treatment of sick children by paraprofessionals.

C.3 Sustainability

Although issues regarding sustainability are discussed more fully in the next section of the report, the evaluation team extracted the following key lessons which are applicable in promoting the sustainability of other PVO CS projects or relevant to **USAID** support to these projects:

Community Participation

- SCSP has been successful in implementing the ***DEPKES*** policy in the promotion of broad community participation in community development activities and,creating the demand for sustained investment in health.

- Particularly in areas with language barriers and low literacy and educational levels, a prolonged "start-up" phase is required to prepare communities to participate fully in project activities and decision making. Community participation and the ultimate sustainability of project interventions depend on allocating several months for preparation of communities for "goal ownership" and establishing collaboration with both non-formal and formal community institutions.

> *"We have seen other USAID-funded health projects in which benefits cease after project funding is finished. Because of the efforts to ensure community participation, the activities started by this project should be able to continue when it is over. But it is too soon to stop the project now, since the participation and activities are not yet firm enough to continue without assistance."* (*DEPKES* official – Ponti anak)

- Wherever possible, contact with communities and health education should be undertaken using the first language of the people in the project area. Language barriers are important obstacles to full participation, even where people are reportedly able to speak the official language.

- Few governments can provide the type or level of input necessary to maintain the commitment of volunteers for health service delivery. This represents a comparative advantage of **PVOs,** which are frequently successful in mobilizing significant resources without promise of financial compensation.

- Attention should now be given to consolidating project achievements in the development of community organizations, especially the ***dasa wismas*** and ***dana sehats,*** to assure their sustainability. More effort will be required to educate men in order to ensure their concurrence and cooperation with programs designed to improve the status of women.

- Disposable resources available at the household level in these remote areas are significant. "Ability to **pay"** is reflected in the relatively high earnings of rubber harvesters and the frequently large household expenditures on alcohol and gambling during the ***ganjur,*** or harvest festival period.

> ***"The ganjur tradition will not be easy to change. I know one man whose child had died – a death he blamed on his own failure to take part in the ganjur in his village"*** **(Sub-District Chief, Balai-Ingin)**

- Highly visible SCSP interventions in the project area, such as piped water systems, rainwater storage tanks, gardens, and latrines, have helped to galvanize community participation to achieve the less tangible health benefits such as improved health behaviors.

Health Care Financing:

- The linkage of health and economic development programs is powerful in mobilizing resources to improve health. However, there must be constant attention to ensure that health remains a priority, so that it is not lost in economic development efforts.

- Use of traditional institutions, such as the *gotong* royong (a cluster of 10 to 15 households which cooperate in agricultural activities), is an effective strategy in establishing community organizations for health, such as community-based health insurance schemes (*dana sehat*), economic development groups (*KUEP*), and savings groups *(arisans).*

- The sustainability of community organizations which manage pooled funds, such as the health insurance programs (***dana seha*** ts) and savings groups (***arisans***) depends on the perceived **honesty** of the managers and, more importantly, their accountability to the members. Periodic financial reporting to members is a strategy which may be helpful in maintaining the accountability and perception of honesty of management staff.

> ***"This book [the deposit record for the savings group] holds the dreams of the members of the group. It has given us a sense of unity and solidarity to contribute to this..."*** **(Treasurer of the *dana sehat* in Padikaye village)**

- The ceiling on reimbursement for expenditures for health care established by **some *dana sehats*** has been a barrier to **expansion of** the membership in these community-based health insurance schemes.

- The success of the ***dana sehat*** depends on a sense of belonging and commitment among the members. This has been best achieved to date among the Dayak people by organizing these insurance schemes through their clans, although A "critical **mass"** of participants is necessary to make the ***dana sehats*** financially viable.

> **One community-based health insurance organization has been designed as a "health maintenance organization" (HMO), establishing its own *pos obat desa* as a primary health care center for its members. The group has set its own prices for drugs and, after only 2 months, recovered nearly enough funds to repay the cost of the pharmaceuticals originally loaned to start the drug post.**

Will and Capacity of Partner Institutions:

- Several months before the commencement of the project, relationships with partner institutions should be well defined to assure that relative responsibilities for project activities are well established. This early development of a framework for relationships is also critical to assure that the partner institutions can be fully involved by the time of the development of the DIP.

- Time invested to develop support for the project among political leaders was well worthwhile, as this support for SCSP has been instrumental in achieving project objectives and creating demand for continuing investment in health.

- SCSP owes much of its success to the transparency and strength of its collaboration with the government (including

at provincial, district, and subdistrict levels), ***DEPKES,*** the ***PKK,*** and community organizations in the beneficiary communities.

- The government's ongoing process of decentralization to the district level brings increased hope that the public sector, at the district level, can achieve the intersectoral collaboration which good PVO CS projects can achieve. This intersectoral collaboration is required to achieve truly effective and sustainable community development.

> ***"Of course we are satisfied with the accomplishments of the project, SCSP has shown that our own policies regarding intersectoral collaboration can work"*** (***DEPKES*** Director for Community Participation, Jakarta, and ***DEPSOS*** representative, Pontianak)

- The SCSP experience may provide a model to other organizations of a comprehensive and integrated approach to development, including health, environmental, sociobehavioral, and economic interventions.

- Although it was important initially to implement this project in an area with a better developed infrastructure, the demonstrated successes of SCSP may now be generalized and applied in a more remote area during the next phase of the project.

- Although the "will" may be present in the partner institutions (i.e., the *two yayasans) to* sustain CS interventions, a significantly greater investment in organizational development would be required to develop the "capacity" of these institutions to carry on in the absence of the CS project.

- Development of the capacity of the collaborating NGOs in management, technical, and fund-raising skills has been hampered by 1) the turnover in NGO staff, 2) their lack of availability (such as due to residence in urban areas remote from the project site), and 3) their status as volunteers (who must be employed full-time in work outside the *yayasan).*

> ***"More training is needed for the PKK and the yayasans so they will be able to manage programs and obtain funding for health projects"*** (CHW – Empirang Ujung)

C.4 Project Expenditures

A single lesson learned regarding financial management was identified by the evaluation team:

- Training for project staff in financial tracking to meet USAID accounting guidelines was instrumental in ensuring sound financial management practices.

II. PROJECT SUSTAINABILITY

From the outset of the project, SCSP has given first priority to issues of sustainability. Project staff and partners have organized and attended workshops on sustainability and have been trained in development of sustainability action plans and indicators. Both a national and an international consultant have been contracted to assist the project in optimizing its strategy for sustainability. SCSP has discussed the strategies for sustainability with political leaders right down to the village level. This sharing of efforts to find solutions to problems of sustainability is now evident in the awareness and concern regarding these issues among SCSP partners at every level.

A principal SCSP strategy to achieve sustainability is founded on broad collaboration with both public and private sector agencies. In addition to having strong collaborative relationships with partner agencies and communities, SCSP has also been able to profit from networks of other agencies working in health development throughout Indonesia.

Reflecting this strategy of cooperation, the DIP was developed in collaboration with the Ministry of Health (*DEPKES*), the Provincial Governor, the District Chief (*Bupati*) of Sanggau District, the *Camats* (Sub-District Chiefs) of both Balai and Tayan Hilir Sub-Districts, representatives of the two *yayasans* (*YHK* and YSF), the *PKK*, the *LKMD, KUEP, dasa wismas*, primary and secondary schools, *posyandus, dukun bayis*, traditional healers, and *posyandu kaders*. The project also consulted USAID/Jakarta, WHO, UNICEF, UNFPA, other international PVOs (including HKI, PATH, PCI, and ADRA), Survey Research Indonesia, the National Institute for Health Research, and the University of Indonesia (UI) School of Public Health. Dr. Ascobat Gani, Dean of UI's School of Public Health, prepared an extensive report addressing the issues of sustainability as input for the DIP.

From the outset of the project, SCSP staff and consultants have been aware that more than the three year project period would be required in order to achieve sustainability. Yet every project activity has been undertaken with a view to its implications for sustainability of project benefits. Frequently, strategies were selected which would yield greater hopes of sustainability instead of rapid results in achieving quantitative targets for service delivery.

Sustainability of SCSP benefits has also been enhanced through dissemination of lessons learned during project implementation. In national workshops and international conferences, SCSP staff have presented key conclusions and recommendations to assure that others will profit from the experience of SCSP staff. Staff have also prepared an informative and attractive "newsletter" which summarizes several of the key lessons learned during the project period.

A. Community Participation

The project has achieved an impressive level of community participation in the brief duration of this three-year project. A considerable period of time was required, however, to adequately "prepare" these communities to participate fully in health and community development activities. That this investment has "paid-off" is now evident in the obvious sense of community ownership of the goals and activities of Child Survival.

> *"We will continue these activities (including environmental sanitation, gardening, and health insurance schemes) even if SCSP should end, though we need more help now to be able to continue at this level without SCSP."* (Arisan treasurer – Padikaye village)

Community participation is most simply reflected in the rates of utilization of CS services. Although strictly comparable data are not available, it is clear that rates of participation in the ***posyandu*** have increased since the beginning of the project, with 63% of mothers of children under two bringing their children for these services.

Community contributions of time, money and materials also reflect growing participation in CS and development activities. SCSP, with the help of local consultants, has documented the local "ability to pay" as well as "willingness to pay" for CS and community development services. The need for cost recovery is clear; and "self-reliance", including community co-funding, is the national development policy. To date, financial contributions by communities for water and sanitation programs and construction of the ***polindes*** (village delivery homes) amount to over $20,000. In addition, more than $5000 worth of volunteer time (valued at Rp 3,500 per day and Rp 2,200 per dollar) has been contributed for health and community development activities.

The communities' *kaders* provide the most important source of these volunteer human resources to implement project activities. Although there are the ever-present problems in maintaining the motivation and limiting attrition among these workers, both these volunteers and their paid counterparts (CHWs and Area Coordinators) express an impressive commitment to humanitarian work. More work is needed, however, to affirm the importance of these workers within their communities and to develop sources of technical support and refresher training. SCSP staff have an

opportunity to address this need over the next few months, in collaboration with the **PKK,** which has committed resources for these purposes.

> *"Even if the project should stop tomorrow, the kaders would continue to work because they are in their own village. The CHWs would go back to their own villages, but they would be leaders and models, even if the yayasans couldn't continue their salaries."* (Area Coordinator - Area A)

The ***dasa wismas*** **and** ***dana sehats*** have engendered tremendous interest and support in participating communities. These community organizations provide the principal mechanism to mobilize community participation and are critical to both the supply and demand for health services at the community level. The "prognosis" for sustainability of these ***dasa wismas*** and ***dana sehats*** appears good, but more time is needed to consolidate the gains in their development to date and extend these community development organizations to other, more remote hamlets.

Project staff are also working with ***DEPKES,*** other ministries, and the ***PKK*** to provide adequate training and technical support to ensure the effectiveness and sustainability of this community participation. Although the ***LKMD*** (village council) has a potential role, these community structures need more strengthening before they can take a substantial responsibility for sustaining CS interventions. The village youth ***(karung taruna)*** groups which are beginning to function to date also have considerable community support, but will require more attention to ensure the establishment of a clear role and sustainable system for management and guidance.

B. Ability and Willincrness of Counternart Institutions to Sustain Activities

> *"The SCSP has demonstrated that NGOs can collaborate effectively with the government and has shown how to mobilize communities for health"* (Sanggau District Chief)

The political support for SCSP at every level was found by the evaluation team to be truly impressive. Village, subdistrict, district, provincial, and national officials were all aware of SCSP's achievements and expressed a desire to contribute in any way they could to sustain the gains in the beneficiary communities.

Perhaps even more impressive, however, is the clear sense of "ownership" of SCSP by the partner institutions. Even at the village level, the benefits of SCSP were identified with the local government and the *yayasans.* Although the project was known as "SCSP", no one mentioned "World Vision" as the source of SCSP benefits.

The *PKK* is a strong and ubiquitous organization which could be a more central partner for future project activities. The *PKK's* access to resources for training and supervision of the *kaders*, for example, makes this organization an attractive collaborator to ensure sustainability. Although the *LKMD* is *not* as uniformly well developed or supported, GO1 policy makes the *LKMD* an organizational structure which should be taken into account in the SCSP sustainability strategy.

> *"Through the PKK, every village has resources to pay for refresher training for the kaders. If SCSP can help us organize the training, we can be sure that trained kaders will be available in every village"* (*PKK* representative, Pontianak)

Although the willingness is there, the capacity of some of SCSP's partner institutions to sustain project activities requires further development. The two *yayasans* (*YHK* and YSF) have organizational goals which are completely compatible with CS programs. Yet these organizations still need "management, networking, fund-raising, and technical skills", as pointed out in the MTE report, in order to sustain project activities. There have been few serious efforts in capacity building within the *yayasans* in order to prepare for transfer of management responsibility for SCSP. Much more investment in organizational development will be required if these *yayasans* are truly intended to become capable of taking responsibility for CS management and fund-raising. These organizations will require skills in the development and implementation of training programs, social marketing, and in the technical and management support for all the community organizations and health personnel which have been developed through SCSP.

It may, in fact, be preferable to consider alternatives to the expectation that the *yayasans* will take responsibility for sustaining project activities. If such local *yayasans* are not universal in Indonesia, SCSP may be more "generalizable" as a model if responsibility for sustaining project activities can be transferred to a more omnipresent organization such as the *PKK*. A systematic assessment of the sustainability strategy by an expert in organizational analysis and organizational development might be timely. If the *yayasans* are still expected to provide the principal mechanism for sustainability, however, significant investments should promptly be made in their organizational development.

C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

The sustainability plan, activities to ensure sustainability, and the outcomes in implementation of this plan are presented in the tables below:

PROJECT ACHIEVEMENTS IN PROMOTING SUSTAINABILITY

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Obtain consensus on sustainability goals and objectives	1) SAP developed by April 1993 2) 90% of MOU with project partners have incorporated agreements on sustainability by April 1993 3) 100% of project staff have job descriptions spelling out responsibility for actively facilitating sustainability	1) SAP developed by April 1993 2) MOU with project partners incorporate agreements on sustainability 3) 100% of project staff have job descriptions spelling out responsibility for actively facilitating sustainability	A clear consensus has been achieved regarding steps to be taken to ensure sustainability. Some additional capacity-building will be required, however, to fully implement the sustainability plan.
Equip two local NGOs *(yayasan)* with strong fund-raising, management, and technical capability and ensure their institutional and financial capability	1) *19 yayasan* staff trained and functioning as CHWs by September 1995 *2) 5 yayasan* staff training in program and financial management skills by September 1995 *3) 21 yayasan* staff trained in small enterprise development skills by September 1995 *4)* 21 *yayasan* staff trained in social marketing skills by September 1995	1) *19 yayasan* staff were trained and are functioning as CHWs 2) Limited skills have been transferred for program and financial management 3) *YSF* has a savings and loan activity for yayasan staff and runs a boarding house for students *4) Yayasan* staff have been trained in social marketing skills	CHWs have adequate technical skills, however additional investment is needed to increase the capacity of *yayasans* in management and fundraising and to ensure sustainable technical support for project interventions.

PROJECT ACHIEVEMENTS IN PROMOTING SUSTAINABILITY

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Equip and train public sector staff of three ***puskesmas*** and three ***polindes*** in key technical and management skills	1) ***6 puskesmas*** staff trained in PHC/CS management skills by September 1995 ***2) 9 puskesmas/polindes*** staff trained in obstetric emergency care and high-risk pregnancy management by September 1995 ***3) 15 puskesmas*** staff trained in pneumonia treatment and referral by September **1995** ***4) 3 puskesmas*** with functioning cold chain maintenance by September 1995 ***5) 3 puskesmas*** with functioning EPI surveillance by September 1995 ***6) 3 polindes*** functioning to manage obstetric emergencies and high-risk pregnancies by Sentember 1995	1) ***Puskesmas*** staff were trained in PHC/CS management skills ***2)*** One ***puskesmas*** staff physician was trained in obstetric emergency care and high-risk pregnancy management 3) ***Puskesmas*** and ***pos obat desa*** staff have been trained in pneumonia treatment and referral, though antibiotics are not yet available in ***pos obat desas*** ***4)*** The ***3 puskesmas*** have a functioning cold chain ***5)*** The ***3 puskesmas*** have functioning EPI surveillance ***6) 2 polindes*** are functioning to manage obstetric emergencies and identify high-risk pregnancies	***Puskesmas*** staff are using new skills to improve management and supervision of the ***posyandus.*** Sustainable supply systems have been developed to ensure reliable supplies of drugs to the 3 ***pos obat desas*** and 2 ***polindes.*** Staff of both the ***puskesmas*** and ***polindes*** will, however, require further management training and technical support.

PROJECT ACHIEVEMENTS IN PROMOTING SUSTAINABILITY

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Mobilize and strengthen entrepreneurship of key private sector actors in providing alternative CS services	By September 1995: ***1) 195 posyandu kaders*** will be trained and functioning ***2) 18 pos obat desa kaders*** will be trained and functioning ***3) 50 dukun bayis*** will be trained, equipped with TBA kits, and functioning ***4) 19 yayasan*** staff trained and functioning as CHWs	As of September 1995: ***1) 159 posyandu kaders*** are still functioning despite high drop-out rates **2)** Although 18 ***pos obat desa kaders*** have been trained and 3 posts are functioning, none were trained in the recognition and treatment **of** pneumonia ***3) 100 dukun bayis*** have been trained and equipped with TBA kits. Changes in key practices have been variably sustained ***4) 19 yayasan*** staff were trained and are functioning as CS CHWs	Understanding of the importance of entrepreneurship is growing. SCSP has also helped to create professional networks to promote the sustainability of ***kaders*** and the ***dukun bayis***. High attrition rates among ***kaders*** will need to be considered in future strategies for selection and training. **CHWs** have been useful in program development and expansion efforts, but ongoing needs for supervision of ***kaders*** will be addressed in the future by the more easily sustainable ***kader*** coordinators.

PROJECT ACHIEVEMENTS IN PROMOTING SUSTAINABILITY

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Strengthen community structures and capability in CS/CD activities	1) 84 M&supported ***dasa wisma*** (women's) groups would be formed and functioning as basic units of women's empowerment ***2) 39 posyandus*** would be formed and functioning 3) **19** ***LKMDs*** would be responsible to develop and install: • public latrines • 6 gravity-flow water systems • 38 rainwater harvesting tanks • ***3 polindes*** 4) Communities would have participated in the baseline survey, DIP workshop, first annual review, neonatal death survey, midterm and final evaluations	1) ***50 dasa*** *wismas* are formed and functioning ***2) 45 posyandus*** are formed and functioning 3) In the **19** villages, the following have been developed or installed: • 22 public latrines • 9 gravity-flow water systems • 23 rainwater harvesting tanks • ***2 polindes*** • 108 household latrines 4) Communities participated as planned in the baseline survey, DIP workshop, first annual review, and midterm and final evaluations (the neonatal death survey was not done)	Broad and full community participation is evident throughout the project area. The ***PKK*** is now more active in the support of ***dasa*** *wismas.* Communities understand the need and are committed to participation in sustaining water and sanitation improvements and ***polindes.*** Communities have participated fully in all SCSP planning and implementation to date. This participation has resulted in obvious improvements in demand and capacity for management of CS programs.

PROJECT ACHIEVEMENTS IN PROMOTING SUSTAINABILITY

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
Promote financial viability of institution-building efforts through cost recovery, resource generation, and improved cost-effectiveness	By September 1995: *1) 6 dana sehat* (village-based health insurance groups) will be established and functioning 2) A cross-subsidy scheme (sliding scale for service/medicine) will be instituted in *60%* of *polindes* and *pos obat desas* 3) local fund-raising (donations) will be instituted in 3 *desas* to assist in defraying a portion of the project's recurrent costs 4) 12 income generation schemes will be initiated through village development groups (*KUEP*) 5) The project will take steps to improve its operational efficiency 6) The project will take steps to improve its allocative efficiency	As of September 1995: *1) 8 dana sehat* (village-based health insurance groups) are established and functioning 2) All *polindes* and *pos obat desas* are recovering costs according to guidelines agreed upon within these communities 3) Savings and health insurance schemes in several villages include "social" funds which provide support for needy community members who require health services 4) 14 income generation schemes have been initiated through 36 village development groups (*KUEP*) 5) Improvements have been made to increase operational efficiency 6) Although changes have been made to increase SCSP's allocative efficiency, these have been based on qualitative, rather than quantitative data	There is both community and government support for the cost recovery and resource generating activities in the project area. These are growing rapidly and show great promise of being sustainable. Strengthened technical support for these activities will, however, be critical in ensuring continued success. Cost-effectiveness, as reflected by cost per beneficiary, is adequate to help ensure the levels of service delivery will be sustainable by partners after project termination.

III. EVALUATION METHODS

A. Composition of Evaluation Team

The external evaluator for the team and principal author of the evaluation report was Dr. Sally K. Stansfield. Representatives from headquarters and field staff (Dr. were included as required by **USAID.** The following team members all provided substantial contributions to the final evaluation report:

Name	Oraanizational Affiliation
Dr. Sally K. Stansfield	Team Leader, Consultant, Victoria, B.C.
Dr. Sri Chander	WV1 Asia-Pacific Regional Health Advisor
Dr. Larry Casazza	Director, International Health and CS, WVRD, Washington, D.C.
Ms. Chan Pui Si	International Programs, WV/Hong Kong
Ms. Zoe Chan	Accountant, WV/Hong Kong
Mr. Edy Sianipar	Area Manager, WV, Jakarta
Dr. Widyastuti Wibisana	Community Participation Director, ***DEPKES***
Dr. Atiek Sumardiati	Provincial Medical Officer, ***DEPKES***
Dr. Yakub	Provincial Medical Officer, ***DEPKES***
Dr. Maarten Bato	District Medical Officer, ***DEPKES***
Mr. **Ali**	Social Welfare Officer, ***DEPSOS***
Mr. Abdul **Hadi**	District Development Planning Bureau
Mr. Abdul Karim	***Cama*** t, Balai
Mr. Syaparani **Mastar**	***Camat,*** Tayan Hilir
Dr. Ascobat Gani	Dean, School of Public Health, UI, Jakarta
Mr. Andrew Newmarch	WATCH Project Director, WV/Indonesia, Irian **Jaya**
Ms. Rachel Priyo Utomo	Area Supervisor, WV/Indonesia, Central Java
Dr. Mary Wangsarahardja	Consultant, W, UI, Jakarta
Ny Maarten Bato	***PKK*** Representative
Ny Saragih	***PKK*** Representative
Ny Efendi	***PKK*** Representative
Ny Maria Suharto	***PKK*** Representative
Dr. Jones Siagian	***Puskesmas*** Medical Director, Balai
Dr. **Honggo** Simin	***Puskesmas*** Medical Director, Tayan Hilir
Mr. Harjono	***Yayasan Harapan Khatulistiwa***
Mr. Tanzil	***Yayasan Samaria***
Mr. Samuel Wungo	Area Team Coordinator, West Kalimantan, W/Indonesia
Mr. Untung Sidupa	Project Manager, SCSP, W/Indonesia
Mr. Doli Situmeang	Technical Coordinator, SCSP, WV/I
Mr. Alfred Gontha	Training and Development Coordinator, SCSP, WV/I
Mr. Sunarso	Monitoring and Evaluation Coordinator, SCSP, W/I

B. Data Collection

Data needs for the evaluation were defined by the Final Evaluation Guidelines prepared by BHR/PVC for CS-VIII projects ending in 1995. In view of the WV plans to seek additional funding support to continue project activities, SCSP staff outlined some additional questions to be addressed during the evaluation. These are dealt with in the additional "recommendations" section which has been added to the evaluation report as attachment C.

Data collection methods included document review, key informant interviews (of project staff and of institutional and community partners), and observation of project activities. Sixteen of the 19 villages served by the project were visited by one of four groups of evaluation team members during the three days of field visits. A list of project documents reviewed by the evaluation team is provided as attachment D.

Discussions with partners were designed to explore the issues of project achievement and sustainability as outlined in the final evaluation guidelines prepared by USAID/BHR/PVC. All members of the project staff (excepting those on the evaluation team) were interviewed both individually and in groups. A discussion guide prepared for interviews of the project's field staff included the following general areas:

- Description of the worker's roles and tasks
- Adequacy of training provided by the project for the role as outlined
- Special project achievements in the experience of the interviewee
- Any problems encountered in dealing with project partners (including GOI/*DEPKES*, SCSP core team, ***yayasans,*** or community)
- Things which aided achievement of project objectives
- Any constraints, particularly to community organization and promotion of community participation
- Motivation and sustainability of CHWs and ***kaders***
- Which project activities are sustainable (and which not) after the end of SCSP
- Any suggestions to strengthen the project for the future

The evaluation team divided into four sub-groups and spent three days visiting communities in the project area. The remainder of the time was spent in discussions and meetings. Debriefings were provided for government partners at the district level (including district, subdistrict, and village officials) and at the provincial level to report on preliminary findings. A debriefing was also held in Jakarta to inform WV staff, other NGOs, and donor organizations, including USAID.

ATTACHMENTS

ATTACHMENT A

Attachment A

DATA SOURCES AND METHODS FOR CALCULATION
OF INDICATORS FOR ACHIEVEMENT OF PROJECT OBJECTIVES

There were some differences between the indicators required to track progress toward project objectives and the "key indicators" used by USAID's PVO/CSSP. In assessing progress toward project objectives, the evaluation team used the KPC survey data to obtain the closest approximation possible as a measure for each indicator, re-analyzing the MTE survey results as necessary to ensure consistency in methods. Baseline data were not available for review, as the data were hand tabulated and the questionnaires destroyed. Baseline data may, therefore, be less strictly comparable to the other two surveys.

Although the "key indicators" are calculated according to the instructions by PVO/CSSP and reported in the survey report (attachment B), the specific methods of calculation of the indicators for achievement of the project objectives (page 6), are detailed below:

IMMUNIZATION

Childhood immunization coverage was calculated by determining the percent of children 12 to 23 months who were fully immunized (BCG, DPT3, OPV3, and measles vaccines) before they reached their first birthday. Because of earlier GOI policies, measles vaccine was considered valid as long as administered after the age of six months. No effort was made to assure adequate time had elapsed between doses of DPT or polio, although early immunization is unlikely in view of the monthly nature of the *posyandus. Two* children whose records were unavailable during the survey presented card documentation of full immunization before data analysis was finalized, so were included in the numerator. Immunization history was solely the mother's opinion, and was not obtained by inquiring about sites of administration or examination of scars for BCG.

Tetanus toxoid coverage was measured among women aged 15 to 44 who were mothers of infants. Regardless of the pregnancy history, those who had card-documentation of two or more doses were considered immunized. History of immunization probably should have some credibility in this area where not all women are issued maternal health cards to be held by the mother.

CONTROL OF DIARRHEAL DISEASES

Although the ORT "competence" and "coverage" objectives specify children under five, the indicator population is restricted to children under two because of the survey sampling strategy. The coverage or "use" indicator is calculated as for the indicators specified by PVO/CSSP, using the children with report of diarrhea in the past two weeks as the denominator. The competence

indicator selected at the outset of the project required demonstration of the proper mixing of SSS in addition to correct answers to questions regarding continued feeding, fluids, and referral. Since most of these questions were asked only among those whose children had had diarrhea in the past two weeks, the denominator was limited to these mothers.

Mixing was considered "proper" during the demonstration only if mothers chose the appropriate size container from among their own household items (a locally available glass which holds 200 ml), used the correct quantity of salt (one three-finger pinch) **and** sugar (one five-finger pinch), and stirred the contents until in solution. Correct administration was also a component of the definition of "competence", however no data were collected as an indicator of correct administration.

A mother was considered competent if she correctly demonstrated mixing of SSS (including correct performance of the four tasks outlined above), **and** gave correct answers to questions regarding breastfeeding (as much or more than usual or not currently breastfeeding), fluids (as much or more than usual or exclusively breastfeeding), and foods (as much or more than usual or exclusively breastfeeding) given during diarrhea. Knowledge of the correct place for referral was a component of the objective, however these data were not included in the indicator, since they were only indirectly available from the reported behavior of those mothers who actually sought advice during the episode of diarrhea. Although the achievement for this indicator did not approach the target, even these figures are surprisingly high for such complex and demanding indicator. Actual figures for calculation of competence for the mid-term survey were 17 of 65, while in the final evaluation survey 8 of 40 mothers of children with diarrhea in the past two weeks were considered "competent". There was no significant difference between mid-term and end-of-project measures for this indicator.

NUTRITION AND VITAMIN A

The indicator for knowledge of appropriate infant feeding practice was also somewhat complex. However, since the survey instrument asked most questions about practice rather than knowledge, only two relevant questions were used to calculate this indicator. Knowledge of infant feeding practices was considered acceptable if mothers could specify four to six months as the appropriate time for introduction of supplementary foods and were able to specify one or more appropriate additions to the diet of an infant. No effort was made to calculate this indicator at baseline.

Calculation of the vitamin A coverage among children was complicated by the lack of record of any date of administration on the survey instrument. Although part of the project area receives vitamin A in semi-annual mass distribution for children 12 to 59 months of age, the rest of the children receive vitamin

A at the *posyandus.* Therefore, to calculate this indicator, children 18 to 23 months of age were considered "covered" if they had card-documentation of receipt of at least one dose of vitamin A. Although this approach may lead to some overestimate of actual coverage, the best estimates probably lie between the card-documented and history figures reported for the MTE and final surveys. Numerator and denominator data are 36/53 for the MTE and 39/53 for the final survey, reflecting no significant difference.

Distribution of vitamin A to postpartum mothers was initiated by SCSP in the project area. Initial figures, although not measured in the baseline survey, are likely zero. All mothers of infants in the survey were considered, and actual figures are probably closer to those which include history alone. Numerator and denominator data for card-documentation of postpartum vitamin A coverage for the final survey are 98/170.

MATERNAL CARE AND FAMILY PLANNING

For the ANC and PNC coverage objective, mothers of infants were considered "covered" if they had card-documentation of three ANC and one post-natal care visit. Three dates of visits for ANC were recorded only if there was one during each trimester. The post-natal visit was required within 40 days after delivery. Although not measured in the baseline survey, actual figures at the mid-term and end-of-project were 18/172 and 16/170. There is no significant difference between these two measures.

Although the project objective specifies "eligible" couples, non-pregnant mothers of children under two in the survey were considered eligible. Women less than one month post-partum were also eliminated from the analysis. No question regarding the desire for another child was included in the mid-term survey instrument. All women who reported using contraception were included in the numerator, as long as that method was "modern" (as defined by the PVO/CSSP guidelines). Actual figures calculated were 193/288 for the mid-term and 55/223 for the final evaluation. These figures reflect no significant difference.

CARE OF THE SICK CHILD

The indicator for knowledge of AR1 treatment and referral was asked of all mothers of children under two who participated in the survey. Mothers were required to mention two of three signs of the need for treatment or referral, including rapid or difficult breathing, chest indrawing, or inability to drink. Actual figures for the final evaluation survey were 141/300.

ATTACHMENT B

Knowledge Practice and Coverage Survey Analysis Report
Sanggau Child Survival Project Final Evaluation - 1995
World Vision International Indonesia

Acknowledgement:

The Survey Team wishes to thank the people involved in this survey, especially the supervisors and interviewers as listed below .

List of Supervisors:

1. Yoseph Mbengu (MOE)
2. Chairul Anwar (FP Board)
3. Maryani (CHW of Yayasan Samaria)
4. Nur Aswinarsih (PKK of Balai Sub District)
5. Abang Ismail (Health Center, MOH)
6. Rejeki Barus (Health Center, MOH)
7. Samsudin (FP Board)
8. Naftali de Kause (Key Person)
9. Utin Norma (PKK of Tayan Sub District)
10. Paimin (Cadre Network of Balai)

List of Interviewers:

1. Suhermanto (MO Social Welfare)
2. Margaretha Ina (Village Government)
3. Nafis (Prominent People)
4. Anastasius (Teacher)
5. Gudet (CHW of Yayasan Samaria)
6. Mardan (SW of Yayasan Samaria)
7. Yuniarsih (CHW of YHK)
8. Lusia Luncin (Cadre Network of Tayan hilir)
9. Herman (SW of Yayasan Samaria)
10. Sutata (Teacher)
11. Agustiono (Health Cadre)
12. Marjun (CHW of Yayasan Samaria)
13. Norma Yuwita (CHW of Yayasan Samaria)
14. Antonius Acai (CHW of Yayasan Samaria)
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I. Executive summary

Final Evaluation Knowledge Practice, and Coverage Survey **was** carried out in 30 out of 84 hamlets in Balai and Tayan Hilir Sub-districts of Sanggau District, West Kalimantan, August 28 to September 3, 1995. This survey is completed through a very good collaboration among many local institutions and organizations, viz. MOH, BKKBN, Local Government **Officials,** MOE, PKK, Health Cadres and Key Persons. The objective of the survey **was to** measure the health knowledge and practices of mothers with children under two years in project's impact **areas** compared to the end-off project objective.

The refreshing training in 30 clusters sampling method facilitated by Dr. Mary A. Wangsarahardja, National Health Consultant of **WVI,** Jakarta **Office.** The training for Supervisors as well as the interviewers spent three days prior data collection and the data collection it self conducted within three days by ten groups of interviewers. The data of the survey was managed and analyzed with EPI INFO Program Version 5.01.

Following are major findings of mothers knowledge and practices:

- **Mother literacy**
- **Immunization Knowledge**
  - Timeliness of measles **33.7%**
  - Tetanus toxoid protection **51.3%**
- **Maternal Care Knowledge**
  - Timeliness of Antenatal Care **64.7%**
- **Appropriate of Infant Feeding Practice**
  - Initiation of breastfeeding **69.4%**
  - Exclusive breastfeeding **62.7%**
  - Introduction of food **82.0%**
  - Persistence of breastfeeding **92.0%**
- **Management of Diarrheal Diseases**
  - Continued breastfeeding **90.0%**
  - Continued fluid **67.5%**
  - Continued food **62.5%**
  - Treated with ORT **75.0%**
- **Pneumonia** Control
  - Pneumonia signs **47.0%**
  - Medical treatment **26.7%**
- **Immunization Coverage (Card)**
  - EPI access **84.6%**
  - Measles coverage **68.5%**
  - EPI coverage (full immunized) **66.2%**
  - Drop-out rate of DPT **9.1%**
- **Maternal Care**
  - Maternal Card **36.0%**
  - TT two coverage (Card) **38.2%**
  - One or more Antenatal Visit (Card) **77.3%**
  - Modem Contraceptive usage **69.8%**

II. Methodology

A. Survey questionnaires development.

The questionnaire used for this Final Evaluation KPC Survey was derived principally from the survey questionnaire used to collect information for the Mid-Term Evaluation. Revisions to this questionnaire was made in order to make it easier to understand. Suggestions for the revisions came from the Provincial Health Officials and USAID/Jakarta staff. In addition input was requested of the W/Indonesia staff, survey supervisors, and core team following the MTE survey. One example of a revision: data on service coverage were collected based on cards as well as on history (mother's opinion only).

B. Sample size and sample selection process

Out of the existing 84 hamlets in the two impact areas 30 hamlets/clusters were chosen through a systematic random sampling method. In each of the selected cluster 10 respondents (mothers of (O-23)months babies and children) were chosen following the WHO 30 cluster sampling method of Household random selection. It was agreed that if the total number of the (O-2) months olds in one part of a hamlet (one hamlet can have 3 to 4 far reaching sub hamlets) was 10 or below then random selection of the first Household was not necessary. So a sample of 300 respondents spread over 30 hamlets in 19 villages of two subdistricts were obtained.

C. The training of supervisors and interviewers

Eight of the ten supervisors identified were among those involveld in the MTE survey. The training was focused on improving their skills and ability to work as a team. A session was conducted to review the process, refresh their memory and familiarize themselves with the revised questionnaire.

D. Schedule of Activities

July-Aug.	Survey preparation which includes selecting supervisors and interviewers, determining logistic and cost, revise questionnaire based on MTE-Survey lessons learned, reproducing the survey, and sharing the survey with the institutions involved.
Aug. 28	Training for supervisors
Aug. 28-29	Training for supervisors and interviewers
Aug. 31- Sept 2	Data Collection in 30 hamlets
Sept 2	Data feasibility and data entry
Sept 3	Data entry and analysis

E. Lessons Learned

1. Field Experiences (interviewers report)

- Two mothers refused to be respondents
- Mostly mothers do not know the kind of "technical name" such as Immunization, Pneumonia, kind of Immunization, etc. But even though mother has own terminology in every village such as :

  Immunization = "suntik kebal"
  Pneumonia = "sengeh berat" (Melayu,
  "ngidap singap" (Tebang term)
  Campak = "Kurai" in Tebang term

- Two mothers (respondent 1,3) gave their babies post natal Vit A.

- The fish breeding effort in benua is potential for increase nutrition status of under-five. (Naftali group suggestion)

- Several mothers in Hilir Hamlet said didn't like visit Posyandu because afraid with injection

- MOH staff felt that no significant change of knowledge of mothers for example respondents didn't know named kind of immunization.

- In Benua mostly delivery mother were helped by untrained TBA
- Vit A for mother gave to baby in Cempedak (two cases)

- Suges that survey group who will responsible to the river area should be able to swim.

- Group found that several children in Serinjuk Hamlet afraid to people from outside and use Indonesia language

- Group suggest MOH staff to look for of drugs sale in the villages shop. Because they found unfree drugsin Serinjuk Hamlet.

- There is an impression that the respondents do not know what the purpose of the contraception method they are using is for. One said she desires for another child in the coming 2 years time, yet she is still taking contraception injection and will be taking another one in the coming October. Four other answered : "I don't know , on same question, but they are still on the contraception pills".

2. Core team lessons learned:

- Field testing of the instrument is completely important to be scheduled prior data collection in order to know the weakness the instrument as well as interviewers themselves.

- For mothers who mentioned their Card lost, immunization data should be confirmed to CWH's immunization record.

- Need more explanation about “trimester” determination in order to be clear for interviewers to read mother's/pregnancy card.

- Copy machine should be available in the field and scheduled one day for xeroxing after questionnaire finalized.

- There are space between survey and evaluation so that available opportunity to improve the quality of data management, rest for field staff and prepare evaluation activity.

- Avoid noisy place for data management

- Time interval between MTE and FE was too short to find significant change.

- All of field staff should be involved in the survey activities.

- Each group should consist at least one female to ease introduce group to mother.

III. Result of the Survey

A. IDENTITY - Mother's Age

Age	Freq	Percent	Cumulative
16	2	0.7	0.7
17	3	1.0	1.7
18	7	2.3	4.0
19	14	4.7	8.7
20	28	9.3	18.0
21	19	6.3	24.3
22	34	11.3	35.7
23	16	5.3	41.0
24	19	6.3	47.3
25	30	10.0	57.3
26	8	2.7	60.0
27	18	6.0	66.0
28	16	5.3	71.3
29	6	2.0	73.3
30	27	9.0	82.3
31	12	4.0	86.3
32	7	2.3	88.7
33	4	1.3	90.0
34	6	2.0	92.0
35	10	3.3	95.3
36	2	0.7	96.0
37	2	0.7	96.7
39	1	0.3	97.0
40	5	1.7	98.7
41	1	0.3	99.0
42	1	0.3	99.3
44	1	0.3	99.7
45	1	0.3	100.0
Total	300	100.0	

Sume of ages: 7721 .OO
Mean: 25.74
Standard deviation: 5.52

Children's Age

Age	Freq	Percent	Cumulative
0	11	3.7	3.7
1	22	7.3	11.0
2	17	5.7	16.7
3	18	6.0	22.7
4	15	5.0	27.7
5	15	5.0	32.7
6	8	2.7	35.3
7	10	3.3	38.7
8	18	6.0	44.7
9	10	3.3	48.0
10	15	5.0	53.0
11	11	3.7	56.7
12	11	3.7	60.3
13	12	4.0	64.3
14	14	4.7	69.0
15	11	3.7	72.7
16	13	4.3	77.0
17	16	5.3	82.3
18	16	5.3	87.7
19	12	4.0	91.7
20	8	2.7	94.3
21	7	2.3	96.7
22	4	1.3	98.0
23	6	2.0	100.0
Total	300	100.0	

Sume of ages: 3046.00
Mean: 10.15
Median: 6.65

B. EDUCATION AND IGA

Mother's education (N=300)

33.0% Mothers report being illiterate
10.0% Mothers attended primary school, but do not read
34.3% Mothers attended primary school and do read
22.7% Mothers went to secondary school or more

Income Generation Activities (multiple answer/N=300)

31.7% Nothing
1.7% Handicraft
53.3% Food crop agriculture
8.3% Village shop and supplier
53.7% Rubber harvesting
1.7% Animal husbandry
2.0% Government worker
1.7% Others

Who take care the child while mother away from home (n=300)

33.7% Never away from home
10.7% Mother brought the child with her
12.3% Husband
15.7% Older children
31.7% Relative

C. NUTRITION AND BREASTFEEDING

Breastfeeding (N=300)

95.0% Yes
5.0% Stopped

Stopped breastfeeding (n=15)

40.3% Since the child was born
13.3% less than four months
13.3% 4-6 months
6.7% 6-12 months
26.7% More than 12 months

Breastfeeding - timeliness (n=294)

50.3% Within one hour after delivery
19.0% 1-8 hours after delivery
30.6% More 8 hours after delivery

Vitamin A Capsule for postparthum mother (n=170)

38.2%	Yes, record on GMC
18.8%	Yes, do not record on GMC
40.0%	Did not receive
2.0%	Other

What is vitamin A for (n=300)

42.7%	Prevent night blindness

Food rich of Viamint A, multiple answer (n=300)

20.0%	Do not know
75.3%	Green vegetable
43.7%	Red fruit
38.7%	Meat, fish, core
9.3%	Breastfeeding
11.7%	m l yolk
5.7%	Others

Vitamin A capsule for children 12-23 (n=130)

52.3%	one dose and record on card
11.5%	one dose, do not record
16.2%	two doses and record
4.6%	two doses, do not record
15.4%	never received

Introduction food (multiple answer), n=300

67.6%	Nothing/exclusive breastfeeding (n=68)
49.3%	Water
27.7%	Bottle milk, formula
67.0%	Solid, semisolid food
42.0%	Fruits
49.0%	Vegetable
45.7%	Meat, fish, egg
34.3%	Peanuts
19.0%	Sugar, honey

Additional food other than breastfeeding (n=300)

33.7%	O-3 months of age
53.3%	4-6 months of age
8.0%	More than 6 months of age
5.0%	Do not know

What additional food should be added to Breastfeeding (multiple answer), n=300

16.0%	Do not know
7.7%	Add oil to breastfeeding
50.3%	Food rich of Vitamin A
56.7%	Food rich of iron

D. DIARRHEAL DISEASE

Diarrhea signs, multiple answer, n=300

25.7%	Do not know
28.3%	Vomiting
37.7%	Fever
6.7%	Dry mouth, sunken eyes
49.7%	Diarrhea prolonged
4.3%	Blood in stool
21.3%	Lose appetite
26.0%	Tiredness

Mother action if their child had diarrhea, multiple, n=300

7.7%	Do not know
18.7%	Give fluids
7.7%	Give more drink
4.7%	Give small drink more frequent
70.0%	Give Oralyt/SSS
21.7%	Bring the child to health center
5.3%	Give small food more frequent
1.0%	Withdraw drink
32.0%	Others

Food- recovering diarrhea (multiple answer), multiple, n=300

20.0%	Do not know
48.7%	Give small food more frequent
19.3%	Give food more than usual
13.7%	Give food with high calory
14.0%	Others

Able to make SSS (demonstration), n=300

42.7%	Yes

Children had diarrhea in the last two weeks, n=300

13.3%	Yes

Diarrhea-breastfeeding, n=40

67.5%	More than usual
22.5%	Same as usual
7.5%	Less than usual
2.5%	Stop breastfeed
12.5%	Not breastfeed anymore

Diarrhea-fluids, n=40

60.0%	More than usual
7.5%	Same as usual
17.5%	Less than usual
2.5%	Stop give fluids
12.5%	Did not give fluid other than Breastmilk

Diarrhea-foods, n=40

42.5%	More than usual
20.0%	Same as usual
22.5%	Less than usual
2.5%	Stop give foods
12.5%	Did not give foods other than Breastmilk

Diarrhea-care, multiple answer, n=40

5.0%	Nothing
42.5%	Give oralyt
50.0%	Give SSS
22.5%	Give other fluid
30.0%	Give anti diarrhea (medicine)
22.5%	Other

Diarrhea-sought advise, n=40

45.0%	Yes

Diarrhea-sought **advise to, multiple answer,** n=18

44.4%	Health center
16.7%	Private doctor/health professional
22.2%	Health cadre
22.2%	Traditional healer
33.3%	Relative

E. RESPIRATORY ILLNESS

Pneumonia signs, n=300

19.0%	Do not know
51.7%	Difficult breathing
33.0%	Fast breathing
11.7%	Chest indrawing
6.3%	Loss of appetite
33.0%	Fever
54.0%	Cough
7.0%	Others

Children with cough in the last two weeks, n=300

37.0% Yes

Children with cough and difficult/fast breathing, n=111

40.5% Yes

Mother sought advise for the respiratory illness, n=45

60.0% Yes

Sought advise for the respiratory illness to, multiple answer, n=27

18.5%	Health center
7.4%	Private doctor/health professional
7.4%	Health cadre
0.0%	Trained TBA
18.5%	Traditional healer
44.4%	Relative
11.1%	Drug store Health center
11.1%	Others

F. IMMUNIZATION AND WEIGHING

Did child receive any immunization (based on mother answer, n=300)

74.7%	Yes
25.3%	No

Number of immunization received by her child (base on mother, n=300)

72.7%	Yes, mother can state
27.3%	Do not know

Mother able to name type of immunization (multiple answer, n=300)

36.3%	BCG
29.7%	DPT
38.3%	OPV
39.7%	Measles
12.3%	Hepatitis b
52.2%	Do not know

Measles immunization (timeliness, n=300)

66.3%	Do not know
33.7%	Yes, 9 months

Child has growth monitoring card, n=300

80.7%	Yes
2.7%	Lose
17.3%	No

Immunization for children 12-13 months (based on card), n=115

93.0%	BCG
95.7%	DPT1
95.7%	OPV1
87.0%	DPT3
87.0%	OPV3
21.7%	OPV4
77.4%	Measles
74.8%	Full
42.6%	Hepatitis-l
25.2%	Hepatitis-3

Weighed in the last two months, n=240

15.8%	one time
46.7%	two times
37.5%	none

Nutritional status, n=202

66.3%	upper dot line
32.2%	under dot line
1.5%	under red line

G. MATERNAL CARE

Antenatal visit (based on mother answer, n=170)

22.4%	Never
8.2%	One visit
27.6%	Two visits
17.1%	Three visits
23.5%	Four visits or more
1.2%	Do not know

Received TT during pregnancy (based on mother answer)

25.3%	Never
13.5%	One dose
56.5%	Two doses
4.1%	Three doses or more
0.6%	Do not know

What TT immunization for, n=300

93 = 31.0%	Protect mother and child from tetanus
5.0%	Protect mother
15.3%	Protect child
48.7%	Do not know

How many dose of TT immunization should be given during pregnancy, n=300

3.7%	One dose
41 .0%	Two dose
31 .0%	More than two doses
0.3%	Not necessary
24.0%	Do not know

Has pregnancy/TT card, n=300

108 = 36.0%	Yes
89 = 29.7%	Lost
103 = 34.3%	Do not have

TT immunization (mothers with children <12, based on card), n=79

13 = 16.5%	One dose
62 = 78.5%	Two doses
3 = 3.8%	Three doses
1 = 1.3%	None

Ante natal visit (mothers with children <12, based on card), n=79

13.9%	One visit
39.2%	Two visits
25.3%	Three visits
19.0%	Four visits or more
2.5%	None

ANC-timeliness (mother with children <12, based on card), n=78

33 = 42.3%	First trimester
63 = 80.8%	Second trimester
55 = 70.5%	Third trimester

Post natal visit (mother with children <12), n=170

37.1%	Yes

Are you pregnant ?, n=300

11 = 3.7%	Yes

Want more child within the next 2 years, n=289

55 = 19.0%	Yes
191 = 66.1%	No
43 = 14.9%	Do not know

Use modem contraception, n=234 (include postparthum mother)

157 = 67.1%	Yes

What contraception method does mother/husband use, n=157

0.6%	Tubectomy
0.6%	Implant
47.1%	Injection
50.3%	Pill
1.3%	Others

Firs time ante natal visit, n=300

194 64.7%	O-3 months
53 17.7%	4-6 months
6.0%	7-9 months
1.3%	not necessary
10.3%	do not know

Amount of food for during the pregnancy, N=300

42.3%	More than usual
25.7%	Same as usual
30.7%	Less than usual
1.3%	do not know

What foods are good for pregnant mother (multiple), N=300

7.7%	Do not know
63.7%	Foods rich protein
84.3%	Vegetable rich iron
10.0%	Others

Who cut child's cord when delivery

0.0%	Do not know
0.0%	Mother herself
9.7%	Relative
49.3%	Untrained TBA
28.7%	Trained TBA
12.3%	Health Professional

Table 1
DIP OBJECTIVES AND ACHIEVEMENTS

No	DIP Indicators	Survey Findings of Achievements			EOP Target
		Baseline (11/92)	MTE (9/94)	FE (9/95)	
1	% of children 12-23 months fully immunized by 12 months (BCG, DPT3, OPV3 and measles)	36%	60.1%	66.2%	80%
2	% of women 1544 years detivered in the past 12 months who received 2 doses of TT	10%	32.5%	38.2% C 22.9% H 61.2% T	70%
3	% of all households with children 0-59 months who are competent in ORT usage	-	49.7%	70.0% K 42.7% D	60%
4	% of children O-23 months with diarrhea in the last two weeks who were treated with ORT	27.3%	66.0%	75.0%	60%
5	% of mothers with children O-23 months who know correct weaning and infant feeding practices		54.3%	53.7% t 69.6% F	60%
6	% of children 12-23 months who received appropriate doses of Vitamin A semiannuatfy (card)	19%	64.8%	72.3% C 13.1% H 84.4% T	80%
7	% of women 15-45 years who detivered in the past 12 months who received a Vitamin A dose within one monlh of delivery (card)	0%	33.0%	39.4% c 18.2% H 57.6% T	60%
8	% of eligible couples with under-2 children using modem methods of contraception	80.1%	79.1%	69.8%	85%
9	% of women 15-44 years who delivered in the past 12 months who received 3 ANC and 1 PNC by a trained health person	0%	10.7%	20.3%	60%
10	% of mothers with children O-23 months able to name 2 out of 3 pneumonia signs which indicate a need for treatment or referral	2%	39.7%	47.0%	60%

Note: C=Card, H=History, T=Total, t= correct time, d=demonstrate, F=correct food, K=Knowledge

Table 2
SUMMARY OF SURVEY FINDINGS ON KEY INDICATORS

#	INDICATORS	Survey Findings (%)		
		Base-line	Mid-term	Final
1	NUT: Initiation of Breasfeeding- Percent of infants/children (less than 24 months) who were breast-fed within the first eight hours after birth.	67.1	69.6	N= 204 D= 294 69.4
2	NUT: Exclusive Breasfeeding- Percent of infant under 4 months, who are being given only breast milk	62.8	58.6	N= 52 D= 83 62.7
3	NUT: Introduction of foods- Percent of infant 5 to 9 months. who are being given solid or semi&ii foods	86.1	82.0	N= 50 D= 61 82.0
4	NUT: Persistence of Breastfeeding- Percent of children 20-23 months, who are still breastfeeding (and being given solid/semi-solid foods)	91.7	93.9	N= 23 D= 25 92.0
5	CDD: Continued Breasfeeding- Percent of infants or children with diarrhea in the past two weeks who were given the same amount or more breastmilk	76.1	95.4	N= 36 D= 40 90.0
6	: Continued Fluids- Percent of infants or children with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk	72.8	83.1	N= 27 D= 40 67.5
7	CDD: Continued Foods- Percent of infants or children with diarrhea in the past two weeks who were given the same amount or more food.	45.7	61.5	N= 25 D= 40 62.5
6	CDD: ORT usage- Percent of infants or children with diarrhea in the past two weeks who were treated with ORT	27.3	66.0	N= 30 D= 40 75.0
9	Pneumonia Control: Medical Treatment- Percent of mothers who sought medical treatment for infant/children with cough and rapid difficult breathing in the past two weeks.	39.6	40.6	N= 12 D= 45 26.7
10	EPI: Access- Percent of children 12-23 months who received DPTI	49.5	80.4	N= 110 D= 130 64.6
11	EPI: Coveraae- Percent of children 12-23 months who received OPV3.	41.2	75.0	N=0 0 D= 130 76.9

No	INDICATORS	Survey Findings (%)		
		Base-line	Mid-term	Final
13	EPI: Drop-out Rate- Percent change between DPT1 and DPT3 doses [(DPT1-DPT3):DPT1] for children 12-23 months.	16.7	5.8	N= 10 D= 110 9.1
14	Maternal Care: Maternal Card- Percent of mothers with a maternal card.	15.0	30.3	N= 108 D= 300 36.0
15	Maternal Care: Tetanus Toxoid Coverage- Percent of mothers who delivered in the last 12 months received two doses of Tetanus Toxoid vaccine (based on card).	10.4	32.5	N= 65 D= 170 38.2
16	Maternal Care: Antenatal Visit- Percent of mother who had at least one Antenatal Vi prior to the bii of the child (card+history)	0	68.3	N=3 2 D= 300 77.3
17	Maternal Care: Modem Contraceptive Usage- Percent of mother who desire no more children in the next two years, or are not sure, who are using a modem contraceptive method.	80.1	79.1	N= 157 D= 225 69.8
18	Vitamin A Capsule:- Percent of children 12-23 months who received appropriate doses of VAC semi-annually.	0	64.8	N=1 1 D= 130 85.4
19	Vitamin A Capsule:- Percent of women 15-44 years who delivered in the last 12 months who received a Vitamin A dose within one month of delivery.	0	33.0	N= 8 D= 170 57.6

Additional Information on Key Indicators

Key indicator no. 15 (tetanus toxoid immunization),
Card 65/170= 38.2%
Hist 39/170= 22.9%
Total 104/170= 61.2%

Key indicator no. 16 (antenatal visit),
Card 105/300= 35.0%
Hist 127/300= 42.3%
Total 232/300= 77.3%

Key indicator no. 18 (vitamin A for < 5),
Card 94/130= 72.3%
Hist 17/130= 13.1%
Total 11 O/l 30= 84.4%

Key indicator no. 19 (post-partum vitamin A),
Card 67/170= 39.4%
Hist 31/170= 18.2%
Total 98/170= 57.6%

ATTACHMENT C

Attachment C

RECOMMENDATIONS FOR FUTURE PROJECT ACTIVITIES

Although the end-of-project evaluation guidelines do not require recommendations, project communities and local government have requested that W/Indonesia work with them for a few more years to ensure the sustainability of project activities. In view of this, the evaluation team has offered several recommendations for future project and program development. These may be summarized as follows:

Desian and Implementation Strateaies:

- The final evaluation team, echoing the conclusions of the mid-term evaluation, recommends that funding be granted for a follow-on project. In view of the tremendous political and community demand which has been generated-by SCSP, it would be irresponsible to withdraw project support before investing an additional four to five years to consolidate gains and ensure the sustainability of project achievements.

- Extend the project area geographically, to include a more remote area such as Nanga **Harap,** as requested by government partners.

- SCSP benefits are perceived as being equitably distributed, with its benefits being most important for the poor. However, more data should be obtained, such as during surveys, to ascertain the equitable distribution of benefits.

- Focus follow-on project activities should focus principally on two integrated "packages" of CS interventions: 1) to improve the **management of the sick child** (including those with pneumonia, diarrhea1 disease, and malnutrition) and 2) to improve **reproductive health** (including through maternal care, family planning and AIDS prevention).

Health Manaaement Information Systems:

- Now that the vital events reporting and death investigations are being performed routinely, more effort should be invested to assure that managers, health workers and community members experience the utility of this information through feedback and use of the information to revise strategies.

- Train ***puskesmas*** staff in the use of verbal autopsy for investigation of all maternal and child deaths.

- The *posyandu* quality checklist developed by the project may be an effective tool to empower communities to judge the quality of their health services and to structure the

supervisory activities of a community-based ***posyandu*** management team (PMT). To achieve these objectives, the quality checklist should be simplified for use by ***PKK*** members or other community leaders with limited technical training.

- Shift the emphasis, as planned, from achieving quantitative targets to improving quality in management **and service** delivery. Use team approaches to quality assurance or continuous quality improvement, maintaining an active role for community members to assure a client-centered approach to quality improvement. First issues to address to improve quality might include "missed opportunities" (including missed opportunities for family planning as well as for immunization) and establishing standards for monitoring of the quality of ***posyandus*** (through community-based use of the adapted checklist by ***posyandu*** management teams).

- The project should explore use of participatory rural appraisal (PRA) and continuous quality improvement (CQI) tools to help communities prioritize problems, explore their causes, and identify potential solutions. Problems which will most require such community assistance to identify appropriate solutions include malnutrition, identification and treatment of pneumonia, low attendance at the ***posyandu,*** maternal mortality, and household spending during the ***ganjur.***

Human Resources Manauement:

- Continue the move toward phasing out of the **CHWs** from their current roles. These workers might be replaced, as planned, **by "super-*kaders*",** while **CHWs** may be used to expand or extend current project activities.

- Strengthen efforts to sustain the motivation of the ***kaders*** in order to reduce attrition among these volunteer workers. In addition to the periodic refresher training, the project could gather all ***kaders*** (rather than only coordinators) for periodic meetings and create an "association" or "society" in order to enhance solidarity and professionalism among ***kaders.*** This might best be achieved through capitalizing on the current efforts in Area A to reduce attrition through the "survival association".

- Supervision and other CHW activities would be facilitated by provision of sturdy mountain bikes for their transportation.

- Future trainings for CHWs and TBAs and the staff of ***posyandus*** and ***pos obat desas*** should include first aid (*PPPK*) skills to empower these workers to respond appropriately in emergencies.

Immunization:

- Expand the use of PATH's pictorial record of childhood immunizations, posting these records for each child on the wall at the ***posyandu.***
- Strengthen health education regarding immunization, encouraging mothers to expect the common adverse effects, such as fever, and to view these as normal and minor, relative to the health benefits.

Control of Diarrhea1 Disease:

- Review **SCSP's** CDD strategy by 'benchmarking" with other agencies (both governmental and non-governmental) in order to assure that efforts to promote ORT use are optimally appropriate, both technically and culturally.
- Accelerate "social marketing" of ORT, especially during peak seasons for diarrhea, in order to sustain high rates of ORT use and ensure that diarrhea treatment practices remain technically correct.

Nutrition and Vitamin A:

- Since more than three quarters of mothers report that they leave their children with a relative, neighbor, or older child while away from the home, it would be advisable to explore the correlation of these child care practices with the incidence of malnutrition. If these practices are associated with nutritional problems, the project should **systematically** test interventions such as cooperative day care programs for children as an intervention to prevent malnutrition.
- SCSP should promote increased attendance at the ***posyandu*** and identify a strategy to provide effective counseling (such as by a specially-trained worker in a separate room) for individual mothers whose children are malnourished.
- The project should explore additional strategies for improving nutrition, such as de-worming of school-age children. Community financing of this activity in **some** villages in the project area suggests that such an activity would be socially and financially sustainable in Sanggau District.
- Assess the effectiveness of using selected ***dukun bayi*** (TBAs) to distribute vitamin A to mothers at the **time** of delivery.
- Consider the design and evaluation of a program for nutritional intervention to correct adolescent undernutrition at the time of puberty.

Maternal Care and Family Planning:

- Use the "gold standards" checklist (from PVO/CSSP) to assess the adequacy of the current curriculum for TBA training and maternal education.

- Health personnel, especially the ***dukun bayi*** **(TBAs)** should receive skills-based training. Future training for **TBAs** should assure earlier distribution of TBA kits, proper use of equipment, access to a bulb syringe to clear nasopharyngeal secretions, access to scales for birthweights, and plans for continuing education to strengthen skills.

- Expand training of ***dukun bayis,*** in order to improve the proportion of deliveries assisted by a trained attendant. Survey data indicate that nearly two-thirds of deliveries are currently performed by untrained **TBAs.**

- Provide refresher training for the polindes-based ***bidan desas*** (village midwives) in the identification, management, and appropriate referral of obstetric emergencies. Consider working with technical experts, such as through the MotherCare project, to assess the cost-effectiveness of the ***polindes*** strategy in improving delivery outcomes in Sanggau.

- Work with technical experts, such as through the MotherCare project, to explore the feasibility and cost-effectiveness of "insurance" to improve access to transport during obstetric emergencies. Organizations such as the ***dasa wismas*** or ***dana sehats*** may be able to manage the finances and retain owners of locally available vehicles or boats on behalf of pregnant women prior to delivery.

Care of the Sick Child:

- Provide training, supervision, timers, and appropriate first-line antibiotics to the ***pos obat desa kader*** to permit prompt treatment of uncomplicated pneumonia at the village level.

a For this, as well as other interventions which rely on education, local beliefs and practices should be explored before producing messages in the local dialects which are designed to achieve specific improvements in health behaviors.

Community Particination:

- Accelerate the formation of *dasa wismas,* strengthening their role in project activities such as the HMIS, through training members of these community organizations in community-based disease and death surveillance.

- Assist the ***PKK*** and the ***dasa wismas*** in using the community self-monitoring tools and community-based action indicators developed by the ***DEPKES*** Directorate of Community Participation.

- Enhance the effectiveness and networking among community groups by sponsoring and facilitating workshops and/or study tours within the project area. ***Dasa wismas, dana sehats, pos obat desas,*** **TBAs,** and ***polindes*** staff, for example, could all benefit from such opportunities to strengthen their own work through exchange of "lessons learned".

- Explore, with the beneficiary communities, the possibility of making greater use of community youth groups. Although there may not be optimal continuity in the leadership of village youth groups, there is considerable political support and formative impact of activities in the project area which **are** implemented or facilitated by youth groups.

- It is estimated that only approximately **10% to 20%** of households are currently participating in these ***dasa wismas,*** so that future project activities should focus on extending the benefits of ***dasa wisma*** membership to a broader population. Special efforts should be undertaken to assess and assure the equity of distribution of the benefits of these ***dasa wismas.***

- Strengthen technical support for ***KUEP*** activities by ***dasa wismas.*** These groups should be encouraged to seek technical assistance from locally sustainable sources in order to prevent the discouragement associated with recurrent failures of income generating activities. SCSP should promote improved access to TA from areas of expertise including agriculture, animal husbandry, pisciculture, management, marketing, and accounting.

- Encourage continued linkage of economic and health development activities, promoting use of funds (e.g., from "social" funds of ***dana sehats)*** for health-related activities such as to develop water supply **systems** or to insure members in case of the need for obstetric emergency transport.

- Continue the policy dialogue with communities, local government, and the Dayak Cultural Council to identify strategies to limit household expenditures during the ***ganjur*** (harvest festival). Consider raising local consciousness of economic exploitation by *ganjur* organizers and introducing licensure and regulation of the *ganjur.*

- Summarize and disseminate the lessons learned by SCSP in development of *dasa wismas* and *dana sehats.* Strategies to encourage the use of SCSP as a model might include preparation of case studies, sponsorship of a workshop to share experiences among *dasa wismas* and *dana sehats* in the

project area, and publication of a report of 'what works' in developing sustainable community organizations. Consider a research component, in collaboration with Dr. Ascobat Gani, to explore whether'the current policy of including 10 to 15 households provides the ideal or "critical" mass of households to optimize chances of success of this strategy for community-based health care financing.

Will and Canacitv of Partner Institutions:

- Conduct a critical review of the WV experience with its partner ***yayasans.*** In the interest of sustainability, and if SCSP is to be important as a model for generalization to other areas in Indonesia, a review of the national status of ***yayasans*** and their relationship with other organizations active in the health care sector (including *DEPKES, DEPSOS,* the ***PKK,*** etc.) will be required before a commitment is made to continue to work through ***yayasans.***

- If collaboration with ***yayasans*** remains a part of the sustainability strategy, there must be increased investment in organizational development (OD), including through technical assistance in development of an OD plan and strengthened staffing (such as through use of project funds to support a CS technical coordinator) for the ***yayasans to*** ensure increased capacity for management, fund-raising, community development, curriculum development, and training.

- Strengthen partnership with the ***PKK*** (Women's Welfare Movement) as a mechanism to shift greater control to communities for development of the ***dasa wismas*** and ***dana sehat,*** for provision of refresher training and supervision of the ***kaders,*** and for management and supervision of activities at the ***posyandu.***

ATTACHMENT D

Attachment D

PROJECT DOCUMENTS REVIEWED

Baseline Survey. Sanggau Child Survival Project, World Vision International Indonesia, November 1992.

Consultant Report on the Detailed Implementation Plan (DIP) of the Sanggau Child Survival Project. Prepared for World Vision International by Dr. Ascobat Gani, February ***1993.***

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First Annual Report: Sanggau Child Survival Project, West Kalimantan, Indonesia. World Vision Relief and Development, Monrovia, November **1993.**

Overview of Sanggau Child Survival Project. SCSP, Sanggau, **1994.**

Trip Report: Health Management Information System Review. Henry D. Kalter, Johns Hopkins University and Sri Chander, World Vision International, July 1994.

WVRD/Indonesia FY92, Midterm Evaluation Report, Sanggau Child Survival Project. World Vision/Indonesia, October **1994.**

Growth Monitoring Survey Results. SCSP, Sanggau, April 1995.

Sanggau Child Survival Project: A World-Vision USAID Project in Indonesia (Newsletter). World Vision/Indonesia, May **1995.**

Report of a Trip to Indonesia: Way 17 - June 1, 1995. Eric S. Starbuck, Project Officer, AID/BHR/PVC/CSH, July 1995.

Report of Pilot Testing of *Posyandu* Supervisory Checklist. Sanggau Child Survival Project, Sanggau, August **1995.**

Significant Strategy and Achievements **After Mid-Term Evaluation.** SCSP, Sanggau, September 1995.

Recommendations of Mid-Term Evaluation and It's Follow-Up. SCSP, Sanggau, September 1995.

Lessons Learned of SCSP Working in Rural Area of West Kalimantan, 1992-1995. SCSP, Sanggau, September **1995.**

ATTACHMENT E

SANGGAU CHILD SURVIVAL PROJECT

FAO-0500-A-00-2042-00 PIPELINE, Expenditures to-date Sept 30/95
October 1, 1992 to September 30, 1995

Indonesia

PIPELINE	10/1/92 to 09/30/95 BUDGET AID	BUDGET WV	To-Date ACTUAL AID	ACTUAL WV	Balance Expenditure AID	Expenditure WV
L DIRECTCOSTS						
A. Supplies	27,150	8,825	21,720	14,167	5,430	(5,342
B. Equipment	21990	58,850	14,054	55,826	7,936	3,024
C Consultants Services	43,305	0	45,865	0	(2,560)	0
D. Evaluation	31,170	0	23,161	0	8,009	0
E. Personel	161,422	0	194,763	0	(33,341	0
F. Travel/per diem						
1 Local	46,266	0	55,512	0	(9,246)	0
2 International	11,505	0	0	0	11,505	0
G. Other	106,140	0	88,706	0	17,434	0
TOTAL - DIRECT COSTS	448948	676;75	443.78 1	69,993	5,167	(2,318
L INDIRECT COSTS	84,752	1,765	85,945	2,833	(1,193)	(1,068
A Headquarters - 20% of direct costs les Equipment & GM & GIK transport						
B. Allocation of Field Country Administr and Program Support Costs (se schedule)	0	178.310	0	174,924	0	3,386
SUBTOTAL - INDIRECT COSTS	84,752	180,075	85,945	177,757	(1,193)	2,318
GRAND TOTAL	533,700	247,750	529,726	247,750	3,974 I	0